Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Dermatology Referral Form

1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400/ 479-464-8838

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):______________________ Date Needed:______________________ ❑Need Nurse ❑Need Training

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Patient Soc. Sec#: Date of Birth: / /	Phone: ( ) Fax: ( )
Sex: ❑ Male ❑Female Weight lbs/kg Height	Nurse/Key Office Contact:
Allergies:	Tax ID#

CLINICAL INFORMATION *(Please FAX recent clinical notes, labs, tests & current medication list with prescription)*

Diagnosis
❑ L20.____ Atopic Dermatitis ❑ L40.0 Psoriasis vulgaris
❑ L40.8 Other psoriasis ❑ L40.9 Psoriasis, unspecified
❑ L40.5 Psoriatic Arthritis ❑ L73.2 Hidradenitis suppurativa
❑ L70.0 Nodular acne ❑Other__________________

Location of affected area(s): ❑Hands ❑Feet ❑Scalp ❑Groin ❑Nails ❑Other________________________________

BSA affected _________%

Prior and Current Treatment *(please attach list if necessary)*
Is the patient currently being treated or previously been treated for diagnosis indicated? ❑Yes ❑No
If yes, name the product(s), approximate date range(s) and response/outcome, listing current therapy first if applicable.
Product:_________________________ Date Range:________ to ________ Response/outcome:________________
Product:_________________________ Date Range:________ to ________ Response/outcome:________________
Does patient have any contraindications or intolerances to any medications? ❑Yes ❑No
If yes, please name medication and describe contraindication or reaction?________________________________
TB/PPD test given? ❑Yes ❑No Date:_________ Results?_____

PRESCRIPTION

DRUG	DIRECTIONS	QUANTITY	DOSAGE FORM	REFILLS
Cimzia®	❑ Inj. 400mg SC at weeks 0, 2 & 4 **OR** ❑ Inj. 400mg SC every 2 weeks	❑ 6 x 200mg/mL PFS	❑ PFS Starter Kit	0
	❑ Inj. 200mg SC every 2 weeks **OR** ❑ Inj. 400MG SC every 4 weeks	❑ 2 x 200mg/mL	❑ PFS	_____
Cosentyx®	❑ Inj. 300mg SC at weeks 0, 1, 2 and 3 ❑ Inj. 150mg SC at weeks 0, 1, 2 and 3	❑ 8 x 150mg/mL ❑ 4 x 150mg/mL	❑ Sensoready® Pen ❑ PFS	0 0
	❑ Inj. 300mg SC at week 4, then every 4 weeks thereafter ❑ Inj. 150mg SC at week 4, then every 4 weeks thereafter	❑ 2 x 150mg/mL ❑ 1 x 150mg/mL	❑ Sensoready® Pen ❑ PFS	_____ _____
Dupixent®	❑ Inj. 600mg SC on day 1	❑ 2 x 300mg/2mL	PFS	0
	❑ Inj. 300mg SC at day 15 and every 2 weeks thereafter	❑ 2 x 300mg/2mL	PFS	_____
Enbrel® *Adult*	❑ Inj. 50mg SC twice weekly (72-96 hours apart) for 3 months	❑ 8 x 50mg/mL	❑ Sureclick® Autoinjector ❑ Mini™ Cartridge ❑ PFS	2
	❑ Inj. 50mg SC once weekly	❑ 4 x 50mg/mL		_____
	❑ Other: ______________________________	❑ __________	❑ ______________	_____
Humira® *Adult*	❑ Psoriasis Starter: Inj. 80mg SC Day 1, then 40mg on Day 8, then 40mg every OTHER week thereafter	❑ 1 x 80mg/0.8mL & 2 x 40mg/0.4mL**CF**	❑ Starter Kit Pens	0
		❑ 4 x 40mg/0.8mL	❑ Starter Kit Pens	
		❑ 4 x 40mg/0.4mL **CF**	❑ PFS ☐ Pens	
	❑ Psoriasis Maintenance: Inj. 40mg SC every 2 weeks	❑ 2 x 40mg/0.4mL **CF** ❑ 2 x 40mg/0.8mL	❑ PFS ☐ Pens	_____
	❑ Hidradenitis Suppurativa Starter: Inj. 160mg SC Day 1, then 80mg on Day 15	❑ 3 x 80mg/0.8mL **CF**	❑ Starter Kit Pens	0
		❑ 4 x 40mg/0.8mL	❑ PFS ☐ Pens	0
	❑ Hidradenitis Suppurativa Maintenance: Inj.40mg SC on day 29 and once every week thereafter	❑ 4 x 40mg/0.4mL **CF** ❑ 4 x 40mg/0.8mL	❑ PFS ☐ Pens	_____
Ilumya™	❑ Inj. 100mg SC at week 0,4 and every 12 weeks thereafter	❑ 1 x 100mg/1mL	❑ PFS	_____
Otezla®	❑ Take as directed by mouth per package instructions	❑ 55 tablets	❑ Starter pack 28 day	0
	❑ 30mg by mouth twice daily	❑ 60 tablets	❑ 30mg tablet	_____
Siliq™	❑ Inj. 210mg SC once weekly at weeks 0,1 and 2, then 210mg every 2 weeks	❑ 4 x 210mg/1.5mL	❑ PFS	0
	❑ Inj. 210mg SC every 2 weeks	❑ 2 x 210mg/1.5mL	❑ PFS	_____
Stelara® *Adult*	❑ **≤ 100kg:** Inj. 45mg SC on day 1 ❑ **≤ 100kg:** Inj. 45mg SC on day 29 & every 12 weeks thereafter	❑ 1 x 45mg/0.5mL ❑ 1 x 45mg/0.5mL	PFS	0 _____
	❑ **>100kg:** Inj. 90mg SC at week 0 ❑ **>100kg:** Inj. 90mg SC on day 29 & every 12 weeks thereafter	❑ 1 x 90mg/mL ❑ 1 x 90mg/mL	PFS	0 _____
Taltz®	❑ Inj. 160mg (2 x 80mg) SC at week 0, then 80mg SC at week 2	❑ 3 x 80mg/mL	❑ PFS ☐ Autoinjector	0
	❑ Inj. 80mg SC at week 4 and every 2 weeks thereafter through week 10	❑ 2 x 80mg/mL	❑ PFS ☐ Autoinjector	1
	❑ Inj. 80mg SC at week 12 and every 4 weeks thereafter	❑ 1 x 80mg/mL	❑ PFS ☐ Autoinjector	_____
Tremfya™	❑ Inj. 100mg SC at week 0	❑ 1 x 100mg/mL	❑ PFS	0
	❑ Inj. 100mg SC at week 4 and every 8 weeks thereafter	❑ 1 x 100mg/mL	❑ PFS	0
	❑ Inj. 100mg SC every 8 weeks	❑ 1 x 100mg/mL	❑ PFS	_____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: ________________________ ________________________________ ________________________________

DISPENSE AS WRITTEN MAY SUBSTITUTE